Buckeye Family Health
Internal Medicine & Pediatrics

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REQUEST FOR MEDICAL INFORMATION

I, _____, being the patient, birth date _____,

social security # _____, hereby authorize the following physician:

_____
name of physician and practice name to receive records FROM

_____
former physician's mailing address, city, state, and zip

_____
OR – former physician's phone number

to release and furnish **Buckeye Family Health** the following medical information: cardiology reports, laboratory reports, radiology reports, progress notes and all other information.

YOU ARE HEREBY AUTHORIZED AND REQUESTED TO PROVIDE THE INFORMATION REQUESTED

Signature_____ Date_____

PLEASE NOTE: I understand this authorization extends to all or any part of records designated above which may include treatment for physical and mental illness, alcohol or drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and may include the results of an HIV test or the fact that an HIV test was performed. I expressly consent to release of information as designated above. I also understand this authorization extends to release of information via U.S. mail, overnight mail, telephone or facsimile machine (fax). This consent if valid for 60 days unless revoked by my written notice, provided records have not yet been released.